ANIMAL HEALTH GROUP

Records Release Authorization

Client Information

Owner's Name: (Last): _____ (First): _____

Address: _____ City: _____

State: _____ Zip Code: _____

Phone: _____ Email Address: _____

Patient Information:

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

Name: _____ Breed: _____

Records Release Info:

Name of person OR veterinary facility records to be released to: _____

Email Address: _____ Fax Number: _____

Why are records being released?: _____

Type of records to be released (check one): ☐ Vaccination Records ☐ Medical Records ☐ Lab Results

I hereby certify that I am the owner or authorized agent of the owner of the above described pet (s). Further, I hereby request and authorize the veterinarians at Animal Health Vet Group to release the requested medical information for my pet (s) to the requested person/company named above. I release the veterinarian and staff from any legal responsibility or liability for the release of information to the extent indicated as authorized herein. This authorization expires 30 days from the date of signature. I understand I may revoke this authorization, but the revocation may not be applied retroactively once the information specified herein has been released.

Owner Signature: _____ Date: _____

Hylan Boulevard Location 2300 Hylan Blvd. Staten Island, NY 10306 • (718) 980-6491
Castleton Avenue Location 710 Castleton Ave Staten Island, NY 10310 • (718) 448-3680
animalhealthgroup.com • hello@animalhealthgroup.com